

## Complete Summary

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### **GUIDELINE TITLE**

Stroke rehabilitation and community reintegration. Identification and management of post-stroke depression. In: Canadian best practice recommendations for stroke care: 2006.

### **BIBLIOGRAPHIC SOURCE(S)**

Stroke rehabilitation and community reintegration. Identification and management of post-stroke depression. In: Canadian best practice recommendations for stroke care: 2006. Ottawa (ON): Canadian Stroke Network, Heart & Stroke Foundation of Canada; 2006. p. 76-9.

### **GUIDELINE STATUS**

This is the current release of the guideline.

The Canadian Best Practice Recommendations for Stroke Care 2006 will be updated every two years to remain current and incorporate new research findings.

## COMPLETE SUMMARY CONTENT

SCOPE  
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 QUALIFYING STATEMENTS  
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## SCOPE

### **DISEASE/CONDITION(S)**

- Stroke, including ischemic and hemorrhagic stroke
- Depression

### **GUIDELINE CATEGORY**

Counseling  
 Diagnosis

Management  
Risk Assessment  
Screening  
Treatment

## **CLINICAL SPECIALTY**

Critical Care  
Emergency Medicine  
Family Practice  
Internal Medicine  
Neurology  
Nursing  
Preventive Medicine  
Psychiatry  
Psychology

## **INTENDED USERS**

Advanced Practice Nurses  
Emergency Medical Technicians/Paramedics  
Health Care Providers  
Nurses  
Patients  
Physician Assistants  
Physicians  
Psychologists/Non-physician Behavioral Health Clinicians

## **GUIDELINE OBJECTIVE(S)**

To synthesize available literature and recommend best practices in stroke care appropriate to the Canadian context

## **TARGET POPULATION**

All patients with stroke

## **INTERVENTIONS AND PRACTICES CONSIDERED**

### **Assessment/Diagnosis**

Patient assessment for depression/initial screening

- Risk factors
- Prior history

### **Management/Treatment**

1. Antidepressant medications (serotonin-specific reuptake inhibitors)
2. Psychological therapy
3. Psychosocial support

## MAJOR OUTCOMES CONSIDERED

- Progress in rehabilitation
- Length of stay

## METHODOLOGY

### METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Secondary Sources)  
Searches of Electronic Databases

### DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

#### Background

Over the past few years, extensive work reviewing stroke care guidelines has been done in Canada. Rather than duplicate this work, the Working Group used as a starting point two recent initiatives: the Canadian Stroke Quality of Care Study (CSQCS), which focuses on acute care, telestroke, and secondary prevention; and the Stroke Canada Optimization of Rehabilitation through Evidence (SCORE) project, which focuses on rehabilitation. These studies of best practices and performance measurement in stroke care flow from four Canadian consensus panels (three for CSQCS and one for SCORE) conducted during 2004–2006.

- CSQCS reviewed stroke guideline recommendations and developed a core set of performance measures for several phases along the continuum of stroke care. This was achieved through modified Delphi survey methodology involving national expert consensus panels, and discussions at Canadian consensus panel meetings using nominal group process methods. Additional rating rounds followed the panel meetings to ensure final agreement on the performance indicators by panel members.
- SCORE identified Clinical Practice Guidelines for stroke rehabilitation, evaluated each guideline's quality of development using the AGREE instrument, and undertook an extensive review process of the guideline content to reach agreement on stroke rehabilitation recommendations for Canada.

The rigorous work of the CSQCS and the SCORE projects formed the foundation of the work of the Best Practices and Standards Working Group (BPS-WG) and provided direction for the identification of Phase I Primary Guidelines and topics.

#### Methodology

The BPS-WG chose a conceptual framework to follow for the identification and selection of stroke recommendations. The Practice Guideline Evaluation and Adaptation Cycle guided development of the recommendations, which included the following steps: systematic searching for existing practice guidelines; appraising the quality of guidelines using a validated tool; content analysis of guideline recommendations; selecting recommendations for inclusion in the BPS-WG document; obtaining external expert feedback on the proposed recommendations.

## Identification of Primary Guidelines

In December 2005, the BPS-WG reviewed the SCORE project's ratings of a number of published stroke care guidelines. Those which had the highest scores on the AGREE tool and/or those which were considered most relevant to the Canadian context were selected as the Primary Guidelines for the development of the Phase I recommendations. It was agreed that additional guidelines (European Stroke Initiative, guidelines released since the SCORE/CSQCS projects were completed) would be considered as required to support the recommendation development process.

## NUMBER OF SOURCE DOCUMENTS

Not stated

## METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

## RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Several rating systems are used by guideline developers to evaluate the strength of the evidence for their recommendations. These systems vary in the nomenclature used (alpha versus numeric), but there is usually reasonable equivalence in the definitions across the levels of evidence. Each recommendation in the original guideline document provides the levels of evidence for the recommendation as well as the reference for the Primary Guideline(s) that were adapted or contributed most to the wording of the recommendation.

Level of Evidence*		Definition
A	I	At least one randomized controlled trial (RCT); or, meta-analysis of RCTs
B	II	Well designed controlled trial without randomization; or, well designed cohort or case-control analytic study; or, multiple time series, dramatic results of uncontrolled experiment
C	III	At least one well designed, non-experimental descriptive study (e.g., comparative studies, correlation studies, case studies); or, expert committee reports, opinions and/or experience of respected authorities
D	IV	Expert committee reports, opinions and/or experience of respected authorities. This grading indicates that directly applicable clinical studies of good quality are absent.
R	R	Recommended good practice based on the clinical experience of the Guideline Development Group

\*Refer to Appendix One in the original guideline document for a detailed table defining the evidence rating system used by each primary guideline referenced in this document.

## **METHODS USED TO ANALYZE THE EVIDENCE**

Systematic Review with Evidence Tables

### **DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

A Stroke Best Practices Recommendations Matrix was developed that mapped other existing stroke-related recommendations and their levels of evidence onto topic areas identified as relevant to optimal stroke care in Canada (i.e., blood pressure management, organization of care).

The list of topics was generated by identifying recommendations with the highest levels of evidence in each of the reference guidelines. Where similar or related recommendations on a particular topic appeared in more than two guidelines, it was added to the topic list. The final list of topics was then cross-referenced with SCORE and the Canadian Stroke Quality of Care Study (CSQCS) studies.

The Best Practices Recommendations Matrix was created through an iterative process of review and discussion among the members of the sub-group and the BPS-WG as a whole.

### **Evaluation of Levels of Evidence**

Each recommendation included in this document was evaluated against several criteria: strength of the available research evidence to support the recommendation; degree to which the recommendation drives system change or processes of care delivery; overall validity and relevance as a core recommendation for stroke care along the continuum of care. The levels of evidence included in this document are determined through a structured ranking system which measures the strength of the results in a clinical trial or research study. The design of the study (such as a case report for an individual patient or a randomized double-blinded controlled clinical trial) and the endpoints measured (such as survival or quality of life) affect the strength of the evidence.

The various types of study designs, in descending order of strength, include:

- i. Randomized controlled clinical trials (double-blinded or nonblinded) are considered the gold standard of study design.
- ii. Meta-analyses of randomized studies offer a quantitative synthesis of previously conducted studies. The strength of evidence from a meta-analysis is based on the quality of the conduct of individual studies. Meta-analyses of randomized studies are placed in the same category of strength of evidence as are randomized studies.
- iii. Nonrandomized controlled clinical trials.
- iv. Case series: population-based, consecutive series; consecutive cases (not population-based); or, non-consecutive cases. These clinical experiences are the weakest form of study design, but often they can be the only available or practical information.

Several rating systems are used by guideline developers to evaluate the strength of the evidence for their recommendations. These systems vary in the nomenclature used (alpha versus numeric), but there is usually reasonable equivalence in the definitions across the levels of evidence. Each recommendation in the original guideline document provides the levels of evidence for the recommendation (see "Rating Scheme for the Strength of the Evidence" field), as well as the reference for the Primary Guideline(s) that were adapted or contributed most to the wording of the recommendation.

## **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Expert Consensus (Consensus Development Conference)  
Expert Consensus (Delphi)  
Other

## **DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

The Best Practices and Standards Working Group (BPS-WG) chose a conceptual framework to follow for the identification and selection of stroke recommendations. The Practice Guideline Evaluation and Adaptation Cycle guided development of the recommendations, which included the following steps: systematic searching for existing practice guidelines; appraising the quality of guidelines using a validated tool; content analysis of guideline recommendations; selecting recommendations for inclusion in the BPS-WG document; obtaining external expert feedback on the proposed recommendations.

### **Drafting of the 2006 Stroke Recommendations**

Once agreement on a core set of reference Guidelines, topic areas, and the content of the Matrix was reached, the Working Group formed four Ad-hoc Groups to:

- Review all recommendations on the Matrix in their areas of expertise
- Propose draft recommendation statements for each topic
- State a rationale for inclusion of the recommendation and its relevance to stroke care delivery or patient outcomes
- Identify any additional reference sources used to guide their decision-making

There were some recommendations from the core reference Guidelines which had high levels of supporting evidence but which did not appear on the draft topic list. These were considered by the Ad Hoc Groups; as a result, some topics were revised and three topics (post-stroke depression, post-stroke shoulder pain, and community rehabilitation) were added. No topics were eliminated.

Following this process, a full set of draft recommendations was presented to a group of 40 stroke experts and relevant stakeholders from across the country during the Best Practices and Standards National Consensus Conference, held in Halifax in April 2006.

Break-out sessions were held in which participants met in groups relevant to their expertise and reviewed a specific set of recommendations. Each group was made up of members of the original Ad Hoc Groups as well as other consensus conference participants who were new to the process. These break-out groups had access to all documentation used to develop the recommendations, particularly the Matrix and its supporting documents. They discussed each proposed recommendation with respect to relevance, current evidence and practice, and challenges to uptake and implementation. Each group then presented the results of their discussion to the full group, and suggested changes were debated and approved, rejected, or tabled for further discussion by the Best Practices and Standards Working Group (BPS-WG).

See Section C.4 in the original guideline document for a description of the methods used to develop performance measures.

## **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

Not applicable

## **COST ANALYSIS**

A formal cost analysis was not performed and published cost analyses were not reviewed.

## **METHOD OF GUIDELINE VALIDATION**

External Peer Review  
Internal Peer Review

## **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

Following the Consensus Conference, the original Ad Hoc Groups reconvened to review the feedback and propose final wording for the 2006 recommendations. This process was complete by June 2006. A final round of external reviews was completed prior to publication.

# **RECOMMENDATIONS**

## **MAJOR RECOMMENDATIONS**

Definitions of the levels of evidence (A-D; I-IV; R) are provided at the end of the "Major Recommendations" field.

**Note from the Canadian Stroke Network/Heart & Stroke Foundation of Canada and the National Guideline Clearinghouse (NGC):** The *Canadian Best Practice Recommendations for Stroke Care: 2006* guideline has been divided into individual summaries. In addition to the current summary, the following are available:

- [Public awareness and responsiveness.](#)

- [Patient and caregiver education.](#)
- [Stroke prevention. Life style and risk factor management.](#)
- [Stroke prevention. Blood pressure management.](#)
- [Stroke prevention. Lipid-management.](#)
- [Stroke prevention. Diabetes management.](#)
- [Stroke prevention. Antiplatelet therapy.](#)
- [Stroke prevention. Antithrombotic therapy in atrial fibrillation.](#)
- [Stroke prevention. Carotid intervention.](#)
- [Acute stroke management. Stroke unit care.](#)
- [Acute stroke management. Brain imaging.](#)
- [Acute stroke management. Blood glucose.](#)
- [Acute stroke management. Acute thrombolytic treatment.](#)
- [Acute stroke management. Carotid artery imaging.](#)
- [Acute stroke management. Dysphagia assessment.](#)
- [Acute stroke management. Acute aspirin therapy.](#)
- [Acute stroke management. Management of subarachnoid and intracerebral hemorrhage.](#)
- [Stroke rehabilitation and community reintegration. Initial stroke rehabilitation assessment.](#)
- [Stroke rehabilitation and community reintegration. Provision of inpatient stroke rehabilitation.](#)
- [Stroke rehabilitation and community reintegration. Components of inpatient stroke rehabilitation.](#)
- [Stroke rehabilitation and community reintegration. Shoulder pain assessment and treatment.](#)
- [Stroke rehabilitation and community reintegration. Community-based rehabilitation.](#)
- [Follow-up and community reintegration after stroke.](#)

### **Best Practice Recommendation**

**Note:** *Post stroke depression is considered an issue that should be assessed for and managed across the continuum of stroke care.*

All patients with stroke should be considered to be at a high level of risk for depression. The clinical team should assess the patient's prior history of depression and previous risk factors of depression as part of the initial screening. All patients with stroke should be screened for depression initially and at three-month intervals or key stages of the rehabilitation process and after rehabilitation services have been discontinued. (**Evidence Level A**)

- Patients diagnosed with a depressive disorder should be given a trial of antidepressant medication, if no contraindication exists. The Working Group makes no recommendation for the use of one class of antidepressants over another; however, side effect profiles suggest that serotonin-specific reuptake inhibitors (SSRIs) may be favored in this patient population. (**Evidence Level I**)
- In patients with severe, persistent, or troublesome tearfulness, SSRIs are recommended as the antidepressant of choice. (**Evidence Level I**)
- Routine use of prophylactic antidepressants is not recommended in post stroke patients. (**Evidence Level I**)



- Patients should be given information, advice and the opportunity to talk about the impact of illness upon their lives. (**Evidence Level B**)
- Patients with marked anxiety should be offered psychological therapy, given by an appropriately trained and supervised practitioner. (**Evidence Level B**)
- Patients and their carers should have their individual psychosocial and support needs reviewed on a regular basis as part of the longer-term management of stroke. (**Evidence Level A**)

## Rationale

Post-stroke depression may affect a patient's ability to participate in therapy, and is associated with slower progress in rehabilitation and increased length of stay. Clinicians need to be watchful and recognize depression before it interferes too much with therapy and the patient's well being. Due to its adverse effects on rehabilitation, it is important to address the symptoms early on in the rehabilitation process. Standardized screening assessments for depression can indicate that depression exists, and can be used to monitor progress. However, there is no single universally accepted tool for the assessment of post-stroke depression. An alternative to verbal scales to assess mood should be sought when assessing someone who is aphasic. The stroke survivor is at greatest risk for the few months after a stroke, especially in the first six months after the stroke. Anxiety should be assessed and treated, especially when found in conjunction with depressive symptoms. Aphasic patients (individuals who have communication problems) provide a unique challenge for assessment and treatment.

## Definitions:

## Levels of Evidence

Several rating systems are used by guideline developers to evaluate the strength of the evidence for their recommendations. These systems vary in the nomenclature used (alpha versus numeric), but there is usually reasonable equivalence in the definitions across the levels of evidence. Each recommendation in the original guideline document provides the levels of evidence for the recommendation as well as the reference for the Primary Guideline(s) that were adapted or contributed most to the wording of the recommendation.

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Level of Evidence*		Definition
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## CLINICAL ALGORITHM(S)

None provided

## EVIDENCE SUPPORTING THE RECOMMENDATIONS

### TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence is specifically stated for each recommendation.

This document is the result of an extensive review of national and international evidence-based stroke best practice recommendations and guidelines.

## BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

### POTENTIAL BENEFITS

Early recognition and treatment of post-stroke depression facilitates the patient's ability to participate in therapy, and is associated with more rapid progress in rehabilitation, and decreased length of stay.

### POTENTIAL HARMS

Not stated

## QUALIFYING STATEMENTS

### QUALIFYING STATEMENTS

It is recognized that resource issues (financial, system, and human) will make it difficult to implement all recommendations in this document. However, the Best Practices and Standards Working Group consider these recommendations to be "gold standard" benchmarks toward which all stroke care services should be striving. Additionally, these recommendations can also serve as significant starting points for lobbying and advocacy work in aid of improved stroke care services.

## IMPLEMENTATION OF THE GUIDELINE

### DESCRIPTION OF IMPLEMENTATION STRATEGY

#### Dissemination and Uptake

Concomitant with the development of the document, consideration was given to methods of dissemination and uptake, including:

- Consultation with research experts in the field of knowledge translation and guideline dissemination across Canada.
- Sharing progress with other Canadian Stroke Strategy (CSS) working groups to ensure alignment and collaboration in dissemination.
- Presentation and discussion during draft stages of development to provincial stroke champions.
- Consultation with other national guideline groups in related fields (hypertension, dyslipidemia, diabetes).
- Presentation for discussion at the Annual General Meeting of the Canadian Stroke Network, with a break-out session on dissemination and uptake.
- Presentation for discussion at the Annual General Meeting of the Canadian Association of Neurological Nurses, and Ontario Stroke Rehabilitation Working Group. Break-out sessions were held to get feedback on the recommendations and have discussion on dissemination and uptake.

Additional knowledge translation activities will be undertaken following initial recommendations release. This will include seeking feedback at local and regional consultation sessions, and providing a guideline review tool for structured feedback as part of the recommendation dissemination package.

#### Core Elements of an Integrated Stroke Strategy\*

The key components required across the continuum as part of a "system" for coordinated and integrated stroke care are identified in the table "Core Elements of an Integrated Stroke Strategy" in the original guideline document. The development of coordinated and integrated stroke strategies at the local, regional and/or provincial/territorial levels should include as many of these components as possible to ensure comprehensiveness of the stroke strategy, although, as stated previously, it is recognized that systemic and resource restrictions may make this difficult for some groups.

\* Adapted from the Ontario Blue Book—Towards an Integrated Stroke Strategy for Ontario—Report of the Joint Stroke Strategy Working Group June 2000; the *Ontario Best Practice Guidelines for Stroke Care*; and the results of the *Canadian Stroke Strategy Information & Evaluation Consensus Panel*, September 2005.

#### System Implications

- Education for primary care and healthcare providers throughout the continuum of stroke on assessment and recognition of post-stroke depression.
- Timely access to appropriate specialized therapies to manage post-stroke depression (medication and counseling as required).
- Mechanisms in place to support caregivers of stroke survivors.

- Optimization of strategies to prevent the recurrence of stroke.
- Definition, dissemination, and implementation of best practices for stroke rehabilitation across the continuum of care.
- Mechanisms for ongoing monitoring and evaluation, with a feedback loop for interpretation of findings and opportunities for quality improvement.

### **Performance Measures**

- Proportion of stroke patients with documentation to indicate assessment/screening for depression was performed either informally or using a formal assessment tool in the acute care or rehabilitation setting following an acute stroke event.
- Proportion of stroke patients referred for additional assessment/intervention for a suspected diagnosis of depression following an acute stroke event.

### **IMPLEMENTATION TOOLS**

Audit Criteria/Indicators  
Patient Resources  
Pocket Guide/Reference Cards

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

## **INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES**

### **IOM CARE NEED**

Getting Better  
Living with Illness  
Staying Healthy

### **IOM DOMAIN**

Effectiveness  
Patient-centeredness

## **IDENTIFYING INFORMATION AND AVAILABILITY**

### **BIBLIOGRAPHIC SOURCE(S)**

Stroke rehabilitation and community reintegration. Identification and management of post-stroke depression. In: Canadian best practice recommendations for stroke care: 2006. Ottawa (ON): Canadian Stroke Network, Heart & Stroke Foundation of Canada; 2006. p. 76-9.

### **ADAPTATION**

Not applicable: The guideline was not adapted from another source.

**DATE RELEASED**

2006

**GUIDELINE DEVELOPER(S)**

Canadian Stroke Network - Disease Specific Society  
Heart and Stroke Foundation of Canada - Disease Specific Society

**SOURCE(S) OF FUNDING**

Government Funding – National Centres of Excellence Program

**GUIDELINE COMMITTEE**

Canadian Stroke Strategy Best Practices and Standards Working Group

**COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE**

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**FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

Not stated

## **ENDORSER(S)**

World Stroke Organization - International Agency

## **GUIDELINE STATUS**

This is the current release of the guideline.

The Canadian Best Practice Recommendations for Stroke Care 2006 will be updated every two years to remain current and incorporate new research findings.

## **GUIDELINE AVAILABILITY**

Electronic copies: Available from the [Canadian Stroke Strategy Web site](#).

Print copies: Available from The Canadian Stroke Strategy, 451 Smyth Road, Room 3105, Ottawa, Ontario K1H 8M5.

## **AVAILABILITY OF COMPANION DOCUMENTS**

The following are available:

- Canadian Stroke Strategy performance measurement manual: a supplement to the Canadian best practice recommendations for stroke care. 2007 May. 35 p. Electronic copies: Available in Portable Document Format (PDF) from the [Canadian Stroke Strategy Web site](#).
- Stroke prevention cards: risk stratification for early stroke recurrence following TIA. 2 p. Electronic copies: Available in Portable Document Format (PDF) from the [Canadian Stroke Strategy Web site](#).
- Integrated stroke care in Ontario: stroke evaluation report 2006. 2007 Jul. 72 p. Available in Portable Document Format (PDF) from the [Canadian Stroke Strategy Web site](#).
- Stroke services and resources inventory: a national survey initiative. 2007 Jun. 36 p. Available in Portable Document Format (PDF) from the [Canadian Stroke Strategy Web site](#).

Print copies: Available from The Canadian Stroke Strategy, 451 Smyth Road, Room 3105, Ottawa, Ontario; K1H 8M5.

Additionally, suggested performance measures are available in the [original guideline document](#).

## **PATIENT RESOURCES**

A variety of patient information resources, including a list of stroke warning signs, is available from the [Heart & Stroke Foundation of Canada Web site](#).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for

them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

## **NGC STATUS**

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